INFECTIOUS DISEASE DOCTORS, PA
AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I hereby authorize the use or disclosure of information from the medical record of:
Patient Name _____ Date of Birth _____Social Security # _____
I authorize the following organization to disclose the above named individual's health information:
Infectious Disease Doctors, PA, One Medical Parkway, Suite 210, Dallas, TX, 75234
This information may be disclosed to and used by the following individual or organization:
_____ Address: _____
For the purpose of: _____
Please release the following:
____ Entire Record
or: ____ Communication Sheet
____ Doctor Notes
____ Nurse Notes
____ Orders/Prescriptions
____ X-Ray/Imaging Reports-from (date) _____ to (date) _____
____ Laboratory Results-from (date) _____ to (date) _____
____ Other (Specify) _____

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. (Please check one)
_____ **Yes**, I consent to the release of this information.
____ **No**, I do not consent to the release of this information.

I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the individual or organization releasing information. I understand that the revocation will not apply to information already released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization expires upon the following date: _____.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not to sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information I can contact Jabina Rajbhandary, Office Manager, at One Medical Parkway, Ste 210, Dallas, TX 75234, Phone 972-484-7700.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Relationship to Patient (If Legal Representative) Witness

COMPLETE ONLY IF INFORMATION IS TO BE RELEASED DIRECTLY TO PATIENT:
I understand that my medical record may contain reports; test results, and notes that only a physician can interpret. I understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding of the information contained in these entries. I will not hold Infectious Disease Doctors, PA or any of its employees liable for any misinterpretation of the information in my medical record as a result of not consulting my physician for the correct interpretation.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Relationship to Patient (If Legal Representative) Witness

Date Request Completed_____ # Pages Copied_____

Charge$_____ Cash_____ Check#_____ CC_____ Initials_____